STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

HOSPITAL STROKE CENTER ATTESTATION OF CERTIFICATION

1. Date of Application for Certification: _____ Certification Expiration Date:_____
2. Name of Hospital: _____
3. Address: _____

   _____
   City State Zip Code
4. Contact Person:_____
5. Contact phone _____ Contact email:_____
6. Certification category (select below and attach a copy of the certificate):
   - ■ Comprehensive Stroke Center
   - ■ Primary Stroke Center Acute
   - ■ Stroke Ready Hospital
7. Certifying organization:
   - ■ American Heart Association
   - ■ Joint Commission
   - ■ Other Nationally recognized Certifying Organization:

     Name of Organization _____

I hereby attest that: (1) I am authorized to execute this attestation on behalf of the hospital identified above; (2) the information set forth in this document and the attachment hereto are, to the best of my knowledge true and accurate; and (3) I will immediately inform the Department if the certification is suspended or revoked.

Authorized signature: _____ Title: _____

Printed name: _____

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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